- STATE

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL, HYGIENE CERTIFICATE OF DEATH

DECEASED NAME 20 DATE OF DEATH MONTH 2b HOUR TYPE OR PRINTS MAUDE FOGWELL BLIZZARD Oct. 30, 1987 2:58 4 RACE 3° SEX 6 AGE (IN YEARS LAST BIRTHDAY) 5 DATE OF BIRTH June 9, 1928 white 59 yrs Female. TO BIRTHPLACE THE OFFOREIGN 76 CITIZEN OF WHAT COUNTRY? 9 BALTIMORE CITY OR COUNTY OF DEATH MARRIED ENEVER MARRIED Kent Co. Maryland USA Kent WIDOWED DIVORCED 10 CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION 12b KIND OF BUSINESS OR Home RFD Bigwoods P.O. B TYPE OF WORK FOR MOST OF WORKING LIFE INDLISTRY Chestertown At Home Accountant (CPA) JOUAL RESIDENCE LIF NURSING HOME OR OTHER INSTITUTION, CIVE REVIDENCE BEFORE ADMINION 21620 13b COUNTY 13e STREET ADDRESS / ZIP CODE 13c CITY OR TOWN 13d INSIDE CITY LIMITS? Maryland Kent (Bigwoods) Chestertown P.O. Box # 56 YES NO XX 4 FATHER'S NAME FRANK FOGWELL HALL'TE TOULSON 60 WAS DECEASED EVER IN U.S. ARMED FORCES? 166 SOCIAL SECURITY NO 17 INFORMANT P.O. BOXES# 56 LYES NO OR UNKNOWN! | LIF YES GIVE WAR OR DATEST 215 38 1743 Allan Blizzard Chestertown, Md. 21620 no 18 CAUSE OF DEATH Enter only one cause per line for a 16 and c PART I DEATH WAS CAUSED BY denoconcurren of Colon with Metostos IMMEDIATE CAUSE (a) DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause a, stoting the DUE TO, OR AS A CONSEQUENCE OF underlying cause last PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART LO CERTIFICATION 190 DATE OF OPERATION 196 CONDITION FOR WHICH OPERATION WAS PERFORMED 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? 20a AUTOPSY? YES NOT YES [21a. ACCIDENT WAS UNDERLYING 21b. TIME OF INJURY 216 HOW INJURY OCCURRED LENTER NATIRE OF INJURY IN ITEM & PAR TOR PAR TO HOUR AM. MONTH DAY YEAR OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDIC AL EXAMINER) PM 214 INJURY OCCURRED 21e PLACE OF INJURY 21f LOCATION AT HOME STREET FACTORY OFFICE FARM ETC I AT WORK 22a I certify that This hospital attended the deceased from. saw the deceased alive on CCL 25 above, ly we idid idid not view the body after death. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated 226 SIGNATURE DEGREE 22c DATE SIGNED ATTENDING MEDICAL STAFF
PHYSICIAN DIRECTOR PHYSICIAN 22d PHYSICIAN'S NAME LIMPE OF PRINT 22e ADDRESS Susan K. Ross Chestertown, Md. 21620 23a BURIAL CREMATION, REMOVAL 23b. DATE 231 NAME OF CEMETERY OR CREMATORY Burial Nov 2, 1987 Chester Chestertown, Md. 21620 Cemeterv

DHMH = 16 60M 7/84

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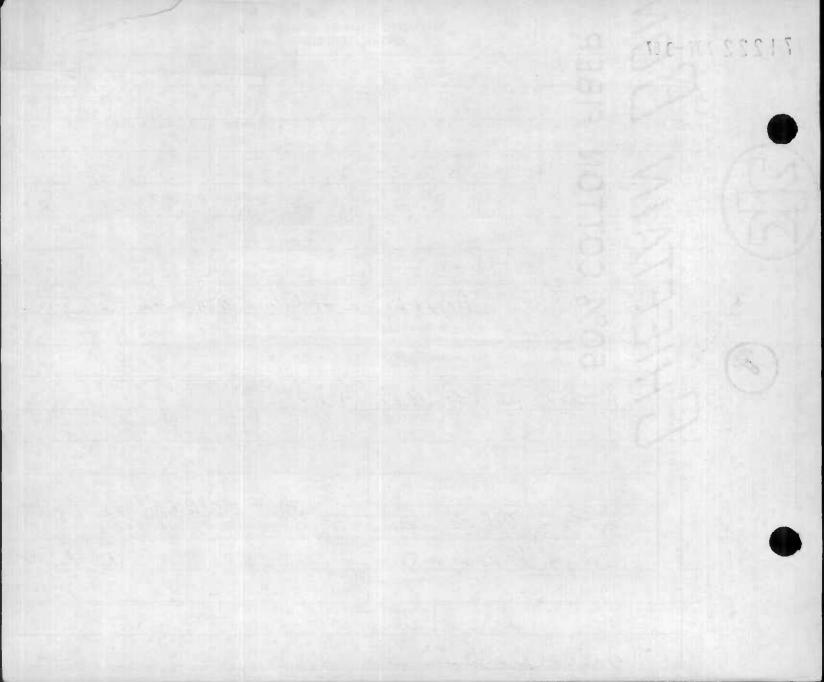
24 FUNERAL DIRECTOR

(VRA 15, 4)

J. Willis Wells

Chestertown, Md.

250 DATE REC D BY REGISTRAR 256 REGISTRAR'S SIGNATURE

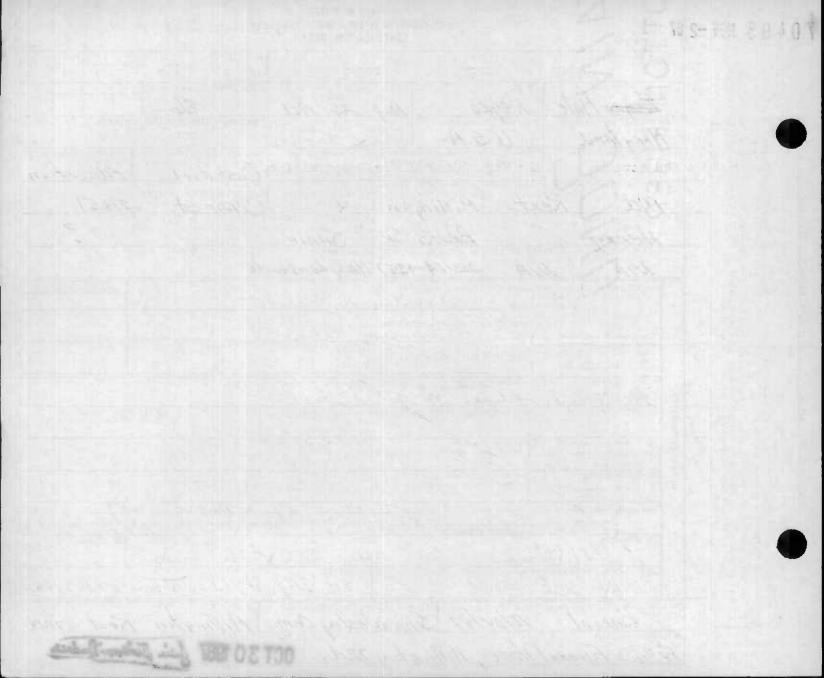


DHMH = 16 60M 7/B4 (VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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BP		BURIAL, CREMATION, REMOV,	AL 23b. DATE 23c	NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN Hilling	ton Kent md.
DHMH = 16 60M 7/84	1 _	UNERAL DIRECTOR	I Show MADDRYS		TE REC'D BY REGISTRAR	



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

STATE REGISTRAR DECEASED NAME 20 DATE OF DEATH MONTH DAY Calvin 75 HOUR John TYPE OR PRINTS 6,1987 October Elburn. xtoxto CKENTHENCY 3 SEX 4 RACE 5 DATE OF BIRTH 6 AGE (IN YEARS LAST BIRTHDAY) April 6, 1925 White Male YRS TO BIRTHPLACE THE OR FOREIGN 7h CITIZEN OF WHAT COUNTRY? BALTIMORE CITY OR COUNTY OF DEATH MARRIED NEVER MARRIED U.S.A. Maryland WIDOWED Kent County ID CITY OR TOWN OF DEATH NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 12a USUAL OCCUPATION 126 KIND OF BUSINESS OR Kent and Queen Anne's Hospital INDUSTRY Chestertown Carpenter and Waterman USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSIONI 136 COUNTY 13c CITY OR TOWN 13e STREET ADDRESS / ZIP CODE 21661 Maryland Kent Rock Hall YES [] Rt. 1 Box 153-A 4 FATHER'S NAME 15. MOTHER'S MAIDEN NAME LAST Alice Virginia Benton C. Elburn Russell 60 WAS DECEASED EVER IN U.S. ARMED FORCES? ADDRESS 166 SOCIAL SECURITY NO 17 INFORMANT IYES NO OR UNKNOWN IF YES GIVE WAR OR DATEST Yes 218-14-4096 Thelma S. Elburn same as above 18 CAUSE OF DEATH (Enter only one cause per line for lat, ib), and ic PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gove rise to immediate cause ia, stoting the DUE TO, OR AS A CONSEQUENCE OF underlying cause last PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a CERTIFICATION 190 DATE OF OPERATION 196 CONDITION FOR WHICH OPERATION WAS PERFORMED 20m AUTOPSY? 206 IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES NOT YES [710 ACCIDENT WAS UNDERLYING 21b. TIME OF INJURY 216 HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN TEM B PART OR PART). HOUR A.M. MONTH DAY YEAR OR CONTRIBUTING CAUSE OF DEATH MEDICAL LIF EITHER NOTIFY MEDICAL EXAMINERS P.M 19 21d INJURY OCCURRED 21e PLACE OF INJURY 21f LOCATION THY OR LOWN AT HOME STREET FACTORY OFFICE FARM ETC) STREET WHILE NOT WHILE 220 I certify that (I) (this hospital) attended the deceased from the deceased alive on_ and that in (my) (our) opinion death accurred on the date and hour and from the causes stated (we) (did) (did not view the body offi 22b SIGNATURE DEGREE 224 DATE SIGNED ATTENDING MEDICAL STAFF
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DHMH 16 60M 7/84 (VRA 15, 4)

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Tom Helfenbein Funeral Home, Rock Hall.

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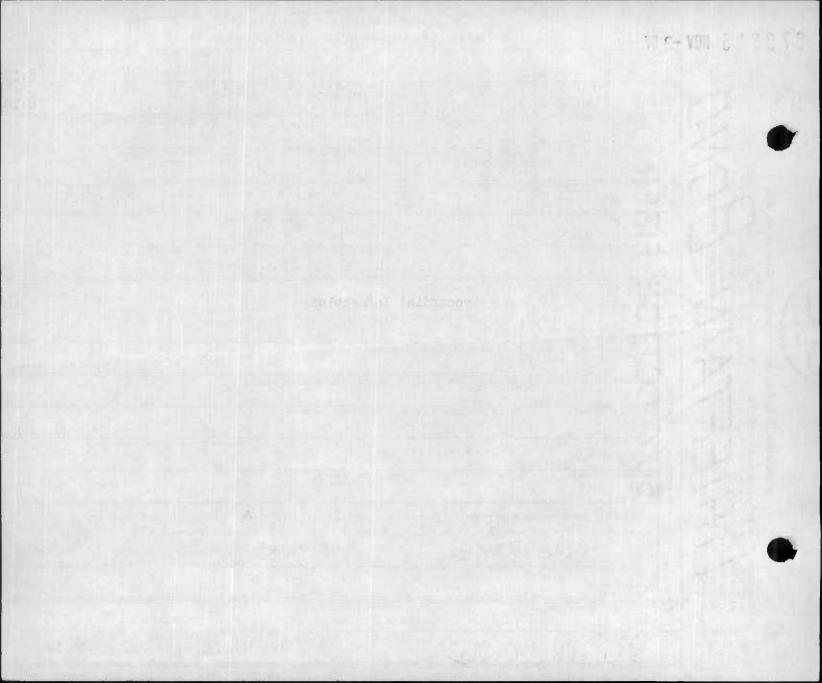
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DHMH 16 60M 7/84 (VRA 15, 4) 24 FUNERAL DIRECTOR

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH DECEASED NAME 20 DATE KNOWN WILLARD B. KINSEY DEATH MATED IF UNDER 1 YR IF UNDER 24 HRS 2c. DATE PRONOUNCED DEAD Oct. 23, 1987 Male white 8:28 Feb 7, 1913 74 76 CITIZEN OF WHAT COUNTRY? 9 BALTIMORE CITY OR COUNTY OF DEATH MARRIED TENEVER MARRIED Kent Co. Maryland USA Kent 11 NAME OF HOSPITAL NURSING HOME, OR OTHER INSTITUTION 120 USUAL OCCUPATION TYPE OF WORK 126 KIND OF BUSINESS Kent & Queen Anne Hosp. Supervisor of Mainteance Chestertown USUAL RESIDENCE HE IN NURSING HOME OR OTHER INSTITUTION. GIVE RESIDENCE BEFORE ADMISSIONA Chestertown 13d INSIDE CITY LIMITS? 13e STREET ADDRESS 21620 Maryland 14 FATHER'S NAME 15 MOTHER'S MAIDEN NAME Fred Kinsey Alice Biggers 17 INFORMANT 160 WAS DECEASED EVER IN U.S. ARMED FORCES? ADDRE Chestertown Elsie R? Kinsey RFD # 2 Box # 748 03 1745 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) PART I DEATH WAS CAUSED BY Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, il ony, which gove rise to immediate DUE TO, OR AS A CONSEQUENCE OF couse (o) stoting the under lying couse last EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EX. TO FUNGEAL DIRECTOR, PAGE 3 SHOULD BE USED AS BURNIAL AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND M. BAUT MORE, MARYLAND, 21201 PROR TO BURNAL, CREMATION PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 III 190 DATE OF OPERATION 196 CONDITION FOR WHICH OPERATION WAS PERFORMED? 20 AUTOPSY? YES NO X 210 EXTERNAL CAUSE WAS 216 TIME OF INJURY 216 HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM TE PART TOR PART 2) HOUR A.M. MONTH DAY YEAR UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21e PLACE OF INJURY FATHOME 211 LOCATION STREET, FACTORY, FARM, ETC.) STREET WHILE NOT WHILE AT WORK CITY OF TOWN COUNTY Inspection X 270 I certify that I took charge of the remains described above, held an death resulted from Undetermined monner TITLE (SPECIFY 10/24/87 ACTUAL SIGNATURE KENT Co. Maryland EXAMINER'S NAME (TYPE OR PRINT) 230 BURIAL, CREMATION, REMOVAL 236 DATE 236 NAME OF CEMETERY OR CREMATORY 10/26/87 Chester Cemetery Chestertown, Md. Burial H FLINERAL DIRECTOR J. Willis Wells DHMH - 17 Autra Divideon Pandage Chestertown, Md. (VR A15 ME (5))



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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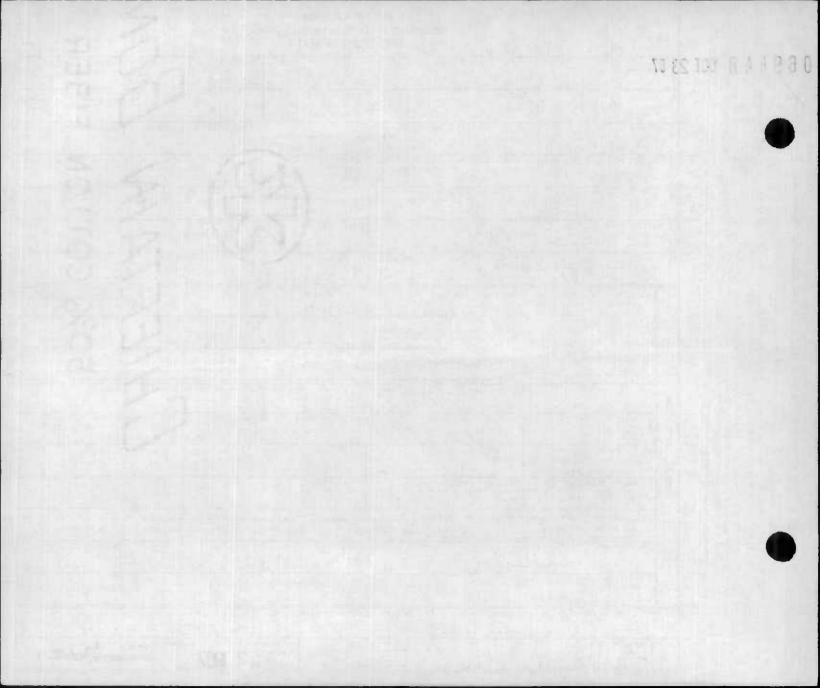
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FOR

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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DHMH 16 60M 7/B4 (VRA 15, 4) STATE

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

Price

CERTIFICATE OF DEATH

20 DATE OF DEATH

10-8-87

2b HOUR

2:35

4. RACE 5. DATE OF BIRTH 6 AGE LIN YEARS LAST BIRTHDAY 3 SEX YRS BALTIMORE CITY OR COUNTY OF DEATH MARRIED NEVER MARRIED COLINITRY Kent 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 12a USUAL OCCUPATION 126 KIND OF BUSINESS OR 10 CITY OR TOWN OF DEATH Kent & Queen Annes CO. Hosptol INDUSTRY Chestertwon, MD 13c. CITY OR TOWN 15 MOTHER'S MAIDEN NAME 14 FATHER'S NAME MIDDLE ADDRESS ARMED FORCES? 18 CAUSE OF DEATH (Enter only one cause per ing for (a), (b), and ic PART I. DEATH WAS CAUSED BY Theumonia IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Canditions, if any, which gave rise to immediate cause (a), stating the DUE TO, OR AS A CONSEQUENCE OF underlying cause last PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110 CERTIFICATION 200 AUTOPSY? 206 IF YES, WERE FINDINGS USED 196 CONDITION FOR WHICH OPERATION WAS PERFORMED IN CERTIFYING CAUSES OF DEATH? NO 🗆 NO YES [210 ACCIDENT WAS UNDERLYING 216 TIME OF INJURY 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART | DR PART 2 HOUR AM. MONTH DAY YEAR OR CONTRIBUTING CAUSE OF DEATH MEDICAL P.M (IF EITHER NOTIFY MEDICAL EXAMINER) 21d INJURY OCCURRED 21a PLACE OF INJURY SIRFET CITY OF TOWN (AT HOME, STREET, FACTORY OFFICE FARM ETC.) NOT WHILE 220 | certify that (1) (this hospitals attended the deceased from_ saw the deceased alive on_ ___, and that in (my) (____) apinion death accurred on the date and hour and from the causes stated abave, (1) (we) (did) (did not) you the body after death 226 SIGNATURE DEGREE 22c. DATE SIGNED ATTENDING STAFF PHYSICIAN [PHYSICIAN 22e ADDRESS 23c NAME OF CEMETERY OR 236 DATE

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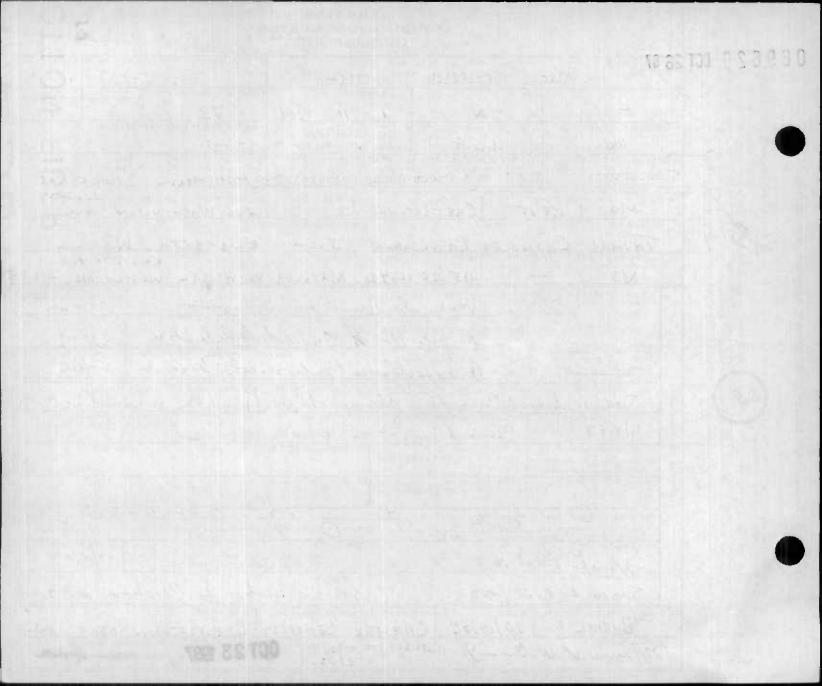
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STATE OF MARYLAND FOR STATE

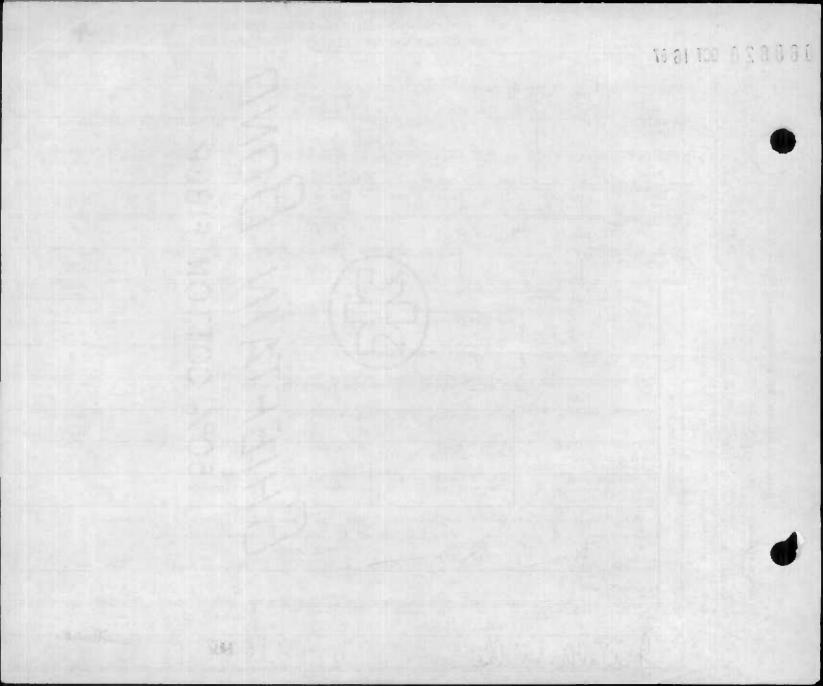
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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cofe	ovol.			18 CAUSE OF DEATH (Enter onl PART I, DEATH WAS CAUSED	ly one couse per line for (a), (b), one			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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h ce	ofic				DUE TO, OR AS A CONSEQUE	NCE DF / A	10011	-/
deo	tion			Conditions, if ony, which	(1b) Probable	Cleude Myocord	il suporets m	I mounte
the the	ertr			gave rise to immediate cause 101, stating the	DUE TO, OR AS A CONSEQUE	NCE-OF ()		
	1			underlying couse lost		claratic Cordiore	- cula Discort	- Syears
(B D	1		-	PART 2 OTHER SIGNIFICANT C		DEATH BUT NOT RELATED TO THE TERM	(() () ()	VEN IN PART 1,0
6.6	1		0		omy for Coraino d tume	n of housverse colon, attic	al tibrillation, dia	botesmellifus, COPD
-	0.0	9	CERTIFICATION	190 DATE OF OPERATION		OPERATION WAS PERFORMED	200 AUTOPSY? 206 IF YE	S, WERE FINDINGS USED IFYING CAUSES OF DEATH?
25 2	1 10	\times	TE	, 1 , (, /	(arcinoid tum	n - housverse colon		ES NO
X 2 0	1 8	-	CE	210 ACCIDENT WAS UNDERLYING	216 TIME OF INJURY HOUR A.M. MONTH DA	21c HOW INJURY OCCURE	RED (ENTER NATURE OF INJURY IN ITEM 18	PARI PARI /
20 17	115	1	AL	OR CONTRIBUTING CAUSE OF DEA	In a	19		
E .	12 3/		MEDICAL	21d INJURY OCCURRED	21e PLACE OF INJURY	211 LOCATION	CITY OR TOWN	CIUNIY
01	113	- 1	Σ	AT WORK NOT WHITE AT WORK	(AT HOME STREET FACTORY OFFICE FA	ARM ETC)	CHYOKIOWIA	TAIL TAIL
D HA	15 2	н		-	al) attended the deceased from	4 19.87	10 CCtoberto	19 E) thot/(I) (we) lost
AT B	7 7 7		- 3	sow the deceased alive on.	October 16 19	ond that in (my) (aur) opinion	death occurred on the date and ho	': /
A POLICE	1 1 5			above, (1)/(we) (did) (did not	view the bady after death	DEGREE		221 DAVE SIGNED
0 0	10 =	П		S V 1/	is m D	ATTENDING	MEDICAL STAFF	10/19/87
THE WAY	115-	1		22d PHYSICIAN'S NAME LTYPE OF		PHYSICIAN L	DIRECTOR PHYSICIAN	
84 83	180/			Susan K. L.			1 101-	testion Md. 21628
5 0	1 3/	-	22- 0			514 Washi		testizin Mol. 21620
DD		ľ	(URIAL, CREMATION, REMOVAL	10/19/87 C	AME OF CEMETERY OR CREMATORY	23d LOCATION	COUNTY
BP			A EL	BURIAL		HESTER CEMETER		
DHMH - 16		2	עק א	Notherway V IN	elle 2 ADDRETTE	STERTUNN, Md 250 DO	BY REGISTRAR 256 REGIS	TRAR'S SIGNATURE
(VRA)	5, 4)		-	1	/	21600	1301	and a factorial



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR 1 - STATE REGISTRAR SDET ASED NAME REG NO 20 DATE KNOWN A MONTH TYPE OR PRINT L DIRECTOR YOUR FILES. N 72 HOURS TON STREET DEATH MATED JUSTIN WINTERS 2d HOUR IF UNDER 24 HRS 2c DATE 15 1987 PRONOUNCED 5:34 Male white Mar 1987 TE CITIZEN OF WHAT COUNTRY? To BIRTHPLACE STATE OR 9 BALTIMORE CITY OR COUNTY OF DEATH MARRIED NEVER MARRIED XX Usa Maryland Kent County O CITY OR TOWN OF DEATH 120 USUAL OCCUPATION (TYPE OF WORK 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION FOR MOST OF WORKING LIFET None Chestertown Kent & Queen Anne's Hospital COUNTY 13d INSIDE CITY LIMITS? 13e STREET ADDRESS Maryland Worton YES 14. FATHER'S NAME Richard Winters Elsie Alonso RFD ADDRESS 160 WAS DECEASED EVER IN U.S. ARMED FORCES? 166 SOCIAL SECURITY NO I HE YES GIVE WAR OR DATEST Richard Winters None Worton, Md. 21678 none 18 CAUSE OF DEATH (Enter only one cause per line for (a, (b), and (c)) A BURIAL - TRANSII PETER I H AND MENTAL HYGIEINE I BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY-IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under-DUE TO, OR AS A CONSEQUENCE OF TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXEC EXECUTE THE CERTIFICATE, WRITING THE WORD "FENDING" PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL CHONERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BUILD RETORE DEATH WITH THE STATE DEPARMENT OF HEATTH AND BALTHAND TO SHEATTH AND SHOULD BE USED AS A BUILD WRITING STATE DEPARMENT OF HEATTH AND SHOULD BE USED AS A BUILD WRITING STATE DEPARMENT OF HEATTH AND SHOULD BE USED AS A BUILD WRITING STATE OF SHOULD SHOULD SHOW TO SHOW TO SHOW TO SHOW THE SHOULD SHOW THE SHOULD SHOW TO SHOW THE SHOULD SHOULD SHOULD SHOW THE SHOULD SHO PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 0 190 DATE OF OPERATION 196 CONDITION FOR WHICH OPERATION WAS PERFORMED? 20 AUTOPSY? YES 🔀 NO J 210 EXTERNAL CAUSE WAS 216 TIME OF INJURY 216 HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) HOUR AM. MONTH DAY YEAR UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21e PLACE OF INJURY (ATHOME 211 LOCATION STREET, FACTORY, FARM, ETC.) CITY OF TOWN WHILE WHILE AT WORK 220. I certify that I took charge of the remains described above, held an Natural causes death resulted from Accident TITLE (SPECIFY) ACTUAL Deputy Chief DICAL EXAMINER SIGNATURE Ann M. Dixon, M.D. EXAMINER'S NAME 111 Penn St., Balto., MD TYPE OR PRINT PAG 7 230 BURIAL, CREMATION, REMOVAL 236 DATE 23¢. NAME OF CEMETERY OR CREMATORY Wilmington, Del. COUNTY Silverbrook Crematory 10/9/87 Cremation 07 84 5 88 TRAR 236 REGISTRINGS OF 25M 24 FUNERAL DIRECTOR J. Willis Wells **DHMH** - 17 Chestertown, Md. (VR A15 ME (5))



9.30

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

STATE REGISTRAR REG. NO 20 DATE OF DEATH 26 HOUR P TYPE OR PRINTS 2,1987 October Ezril Wright Samuel 3 5EX 4 RACE 5. DATE OF BIRTH 6 AGE (IN YEARS LAST BIRTHDAY) JEG 20 To BIRTHPLACE TATE OR FOREIGN Th CITIZEN OF WHAT COUNTRY? BALTIMORE CITY OR COUNTY OF DEATH MARRIED NEVER MARRIED Kent County O CITY OF TOWN OF DEATH NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION 120 USUAL OCCUPATION 126 KIND OF BUSINESS OR (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ITYPE OF WORK FOR MOST OF WORKING LIFET INDUSTRY Kent and Oueen anne's Hospital Chestertown GRESTER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION 13e STREET ADDRESS / ZIP CODE 13c. CITY OR TOWN 13d INSIDE CITY LIMITS? BOX 57 FATHER'S NAME 15 MOTHER'S MAIDEN NAME MIDDLE 60 WAS DECEASED EVER IN U.S. ARMED FORCES ADDRESS 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) AS A CONSEQUENCE OF CUA (83 and recourt) Canditians, if any, which gave rise to immediate cause a stating the DUE TO OR AS A CONSEQUENCE OF underlying cause last PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a NO CERTIFICAT 198 DATE OF OPERATION 206 IF YES, WERE FINDINGS USED 196 CONDITION FOR WHICH OPERATION WAS PERFORMED 20a AUTOPSY? CERTIFYING CAUSES OF DEATH? NO T 210 ACCIDENT WAS UNDERLYING 216 TIME OF INJURY 216 HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART & HOUR AM. MONTH DAY YEAR OR CONTRIBUTING CAUSE OF DEATH MEDICAL (IF EITHER NOTIFY MEDIC ALEXAMINER) P.M 21d INJURY OCCURRED 21e PLACE OF INJURY 211 LOCATION (AT HOME STREET FACTORY OFFICE FARM ETC.) LITY OR TOWN WHILE NOT WHILE 220 I certify that (1) (this hospital) attended the deceased fram_ 10/2 saw the deceased alive an abave, (I) (we) (did) (did nat) view the body after death and that in (my) (aur) apinian death accurred an the date and have and from the causes stated 226 SIGNATURE DEGREE 220 DATE SIGNED Lle ATTENDING MEDICAL PHYSICIAN -DIRECTOR PHYSICIAN 22e ADDRESS 22d PHYSICIAN'S NAME auces Celle

230 BURIAL, CREMATION, REMOVAL

DHMH 16 60M 7/84 (VRA 15, 4)

23¢ NAME OF CEMETERY OR

16:216 F

